Quality improvement: How does it differ from quality assurance?

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Quality improvement? How does it differ from Quality assurance? The "Total Quality Management" movement which has been so successful in improving the quality of manufactured products in Japan and more recently in the United States has arrived in American service industries, including health care. Although a minority of health care institutions has adopted the Continuous Quality Improvement (CQI) or Total Quality Management (TQM) philosophy and techniques on their own, the new Joint Commission on Accreditation of Health Care Organizations (JCAHO) standards to be phased in over the next 3 years require all accredited hospitals to "adopt the new philosophy"[1].

Introduction

This article is intended to familiarize physicians with the philosophy of CQI/TQM as it contrasts with and relates to the approach called Quality Assurance (QA) with which we have become familiar in various phases of its evolution over the past 15 years[2].

In CQI/TQM there is a broader scope than the purely clinical scope of QA; however, this will not be addressed here. For those who are interested in the broader scope of CQI/TQM in administrative processes, planning and organizational integration, the reader is referred to Mizuno[3] and King[4].

Another caveat about the focus of this paper is the use of the heuristic device of contrasting QA and CQI somewhat to the disadvantage of QA. The authors would like to apologize in advance for any slight or offense this may cause to QA advocates. The inspection model of quality control (which is called QA in health care) provides an excellent basis for understanding CQI.

Discussion

The summary of 9 differences between QA (the old way) and CQI (the new way) represented in Table 1 forms the core for the structure of this paper. Each of the 9 differences is stated below as an action to be taken by everyone in the organization.

1. Focus on all processes, not just clinical processes.

In the past, the focus of QA has been clinical care. In an industry that is as interdisciplinary as health care, the focus must be on all types of care and service, not just clinical care. This more comprehensive concept of quality will require "cultivation" by senior leadership, since it requires that improvement be the responsibility of all personnel, not just those designated as "QA personnel" and not just those rendering clinical care to the patient.

For this change in focus to occur, a culture of CQI needs to be cultivated in the entire work environment by the direct advocacy and participation of top leaders in the organization.

2. Eliminate dichotomous standards (met/not met) and continuously improve beyond present performance.

In the past, we have accepted that there is an objective goal (a threshold for a minimum or a "gold standard" as a maximum so to speak) for every process of care. In clinical processes of care, peer reviewers have been asked to evaluate whether or not the "standard" was met. If the standard was met, change did not need to occur.

This is not the case with CQI, where continuous improvement above and beyond any current performance is the goal. The implementation of CQI requires that leadership initiate actions that will allow all personnel to adopt the new way of thinking. These actions include allocating a training and education budget to provide the workforce with a new set of skills (for example, group process and statistical thinking skills) required by CQI.

In addition, top management needs to identify actual best performance (called benchmarking) of competitive organizations and compare internal operations with these high-performance organizations.

3. Cease attributing performance to individuals and look at the overall performance of processes and systems.

Individuals are responsible for only 15% of the variation in processes and outcomes. The system worked in is responsible for the other 85% of variation[5]. Therefore, health care organizations can improve patient care quality—ie, increase the probability of desired outcomes of the care of the patients—by assessing and improving the operational work processes (managerial, clinical, and support processes) that most affect outcomes. This defocusing of individual performance may come as a disappointment (or a relief!) to physicians who believe they are the major determinant of quality in patient care.

Quality Assurance has focused almost exclusively on the performance of individuals rather than on how well the processes in which the individuals participate are guiding them.

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4. Strive to improve the average rather than to eliminate "bad apples"[6].

In order to "improve the average" the focus cannot be exclusively on deviant individuals. For example, when opportunities for improvement have been identified by Quality Assurance, practitioners and departments routinely spotlight the individual closest to the process, and the individual is counseled or "educated." This is not the way to go. Recognizing that 85% of variation is due to "the system", our focus instead must be on improving the process. Unfortunately, improving the process is often more difficult than "educating" the individual. Fortunately, well-established tools are available to assist in the improvement of this process[7].

5. Cease focusing on problems and take advantage of opportunities everywhere for incremental improvement.

Quality Assurance has been the responsibility of Quality Assurance Programs and a small staff of workers. Using established review criteria these workers identify problems requiring peer review or committee review. If problems are not identified using quality review criteria, it is assumed that good quality care is provided and there is no need to change what we do or how we do it. Simply put, "If it ain't broke, don't fix it" has been our approach.

There are many limitations to this approach. First, only a few workers are monitoring the efforts of many. Second, the workers closest to the delivery of care are not in a position to identify areas for improvement or to improve processes they know do not work well. Opportunities are everywhere for incremental change, and every worker must be empowered to participate in the quality improvement effort.

6. Everyone and every process can improve; quality is everyone's responsibility.

The concept of Kaizen[8], or "continuous incremental improvement," is how CQI achieves organization-wide improvement over time. No matter how well a person does, he or she should be preparing and attempting to do better. Maintaining quality no longer should mean "searching for bad apples"; but rather, to teach and lead employees to monitor their own performance and take action to improve everywhere.

In making the transition from QA to CQI, depending on the Quality Assurance Program to improve quality must cease. Every employee should be encouraged to take action to improve the quality of care/service. This will require each of us to evaluate our own process and outcome variables rather than relying on QA "inspectors" to measure our processes and outcomes for us. Again, opportunities are everywhere for incremental change, but every worker must be empowered to participate in the quality improvement effort.

TABLE 1. Comparison of Traditional QA ("The Old Way") to CQI ("The New Way").

"The Old Way"
• Focus is on clinical structures, process and outcomes.
• Dichotomous standards and norms (quality or nonquality, does or doesn't meet standard, guilty or not guilty).
• Individual or departmental performance.
• Statistical outliers ("Bad apples").
• Problems. ("If it ain't broke, don't fix it".)
• Done by QA staff, physician advisors, peer review meetings, and quality assurance committees.
• Detection of errors by inspection and sampling (reactive).
• Solutions generated by providers and managers (usually in a committee meeting).
• Motivated by regulatory compliance (JCAHO) and risk management.
The New Way
• Focus on all processes, not just clinical processes.
• A continuous gradation of performance from present achievement to meeting world-class benchmarks.
• Performance of processes and systems.
• Improving the average.
• Opportunities everywhere for incremental change (Kaizen).
• Done by everyone in the organization.
• Designing-in improvements to prevent errors (proactive).
• Customers (internal and external) involved in design and evaluation of solutions.
• Motivated by the need to succeed (rather than just survive) in an increasingly competitive and hostile environment.

7."Design in" improvements to prevent errors rather than depend on inspection to detect errors.

Quality assurance activities focus on the detection of errors by inspection using pre-established criteria. Review criteria are generic, insensitive, and frequently are applied to all hospital patients. It should not be surprising that "problems" identified by using these generic screening criteria have resulted in time-consuming and costly efforts to determine what is causing the problem. Sometimes the cause of "the problem" is never determined or "the problem" is not considered to be a "problem"; instead, the criteria are criticized, not taking into account the severity of the patient's illness or the characteristics of the particular patient.

If we continue to depend on inspection only, our efforts at improving quality will be ineffective. We need to build quality "in" not inspect bad quality "out".

8. Involve patients, staff, others, in the design and evaluation of solutions.

In the current framework of QA, patient feedback is not systematically collected and thus the patient population factor is not in the equation. When it is, the sample size and/or return rate is often so small that the results are again not representative and as a consequence are frequently discounted (especially if negative).

Patient feedback needs to be encouraged. Standardized survey tools (which are reliable and valid) and techniques must be used to measure both patient satisfaction and patient outcome health status. More informal methods can be used to obtain internal patient input on specific processes being studied for improvement.

9. An orientation toward success, rather than compliance with regulations will motivate us.

Quality Assurance was too often externally driven (by the JCAHO among others) in order to meet outside requirements. If quality is driven only by coercive outside forces, our focus will be to meet the requirements of such agencies. The culture of continuous quality improvement must be fostered in our work environment since our obligation to our patients never ceases.

Conclusion

As our understanding of how to improve the quality of our services to patients and thereby improve their health status continues to evolve, there undoubtedly will be a time in the future when QI is viewed as "the old way" and another "new way" will have been born. There are already some indicators on the horizon that suggest "systems thinking"[9] can supplement and complement total quality management. In health care this could lead to our looking beyond the acute care process and linking health care organizations with our communities through education for health (at all ages), designing processes that prevent environmental degradation, and fostering social and family relationships that can help prevent the many causes of maladaptation and psychosocial distress that are so prominent as causes of illness today.

Although self-referential statements are often frowned upon, continuous improvement of continuous quality improvement doesn't seem like such an unlikely occurrence.

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